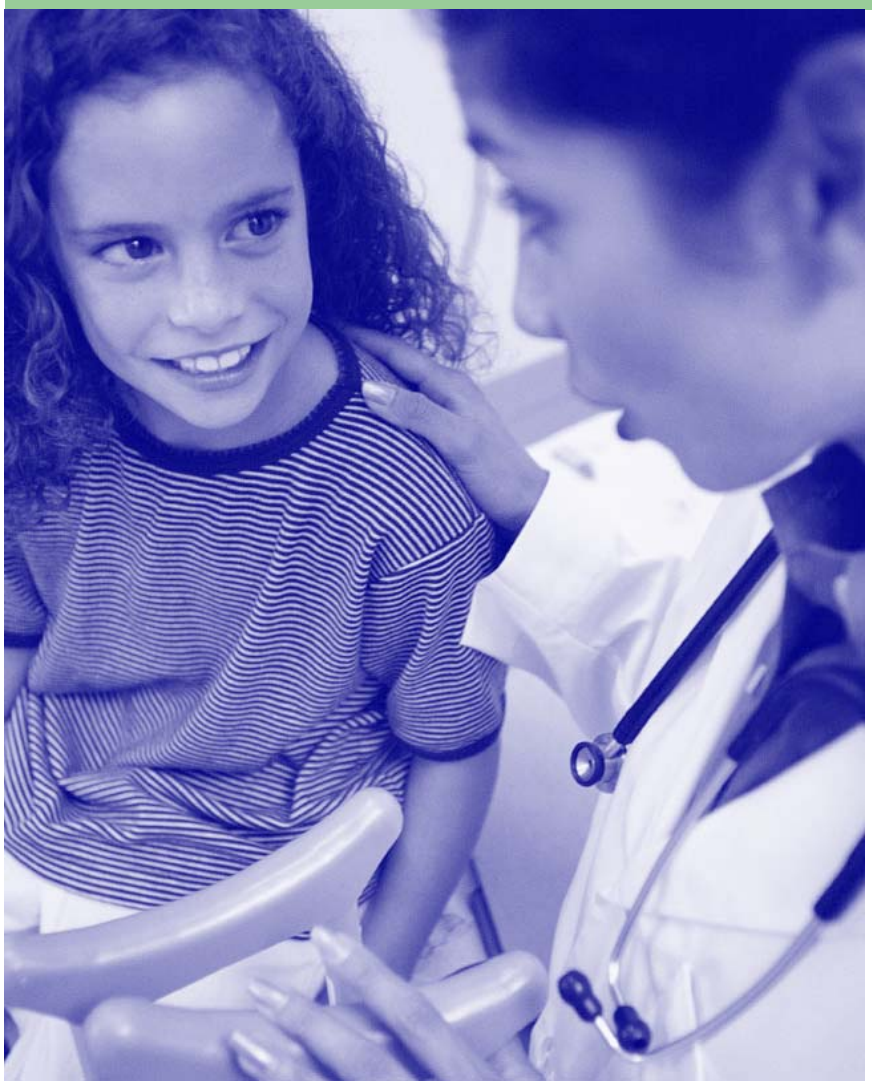
The Office of Health Care Access

Annual Report

To the Governor and Legislature



March 2006

Overview of 2005 Agency Activity

The Office of Health Care Access (OHCA) is responsible for overseeing and coordinating Connecticut's health system. OHCA's mission is to ensure that the citizens of Connecticut have access to a quality health care delivery system. To that end, the agency fulfills it mission by advising policy makers of health care issues; informing the public and the industry of statewide and national trends; and designing and directing health systems development.

OHCA's major functions are administration of the Certificate of Need (CON) program, hospital finance reporting and review, and health care data collection, analysis and reporting. Key aspects of major 2005 agency activities are highlighted below.

- *In 2005, CON applications and determinations reflected several trends: (1) an increasing rate of acquisition of new and replacement equipment by hospitals and doctors' offices; (2) the offering of new or expanded services by hospitals and other health care providers in order to enhance access and quality of available care; and (3) major renovations and upgrades to hospitals' physical space.*

- *The agency's is statutorily required to report annually on the financial status of the states' acute care hospitals. In 2005, OHCA reported that the overall financial health of the Connecticut's hospitals had improved markedly for the prior fiscal year, with the majority of hospitals showing gains in total operating revenue and positive total margins.*

- *OHCA continued its study and assessment of the numerous economic and demographic factors that influence the level of health care coverage in the state. In addition, the agency undertook a study to identify possible gaps in the primary health care system, disease management and access to health services leading to disease severity and ultimately, hospitalization. OHCA also examined whether the licensed hospital psychiatric inpatient bed capacity for children in the state is sufficient and what steps would be required to expand capacity, if necessary.*

- *The agency also prepared proposed changes to its Financial and Inpatient Hospital Discharge Abstract and Billing Regulations, in an effort to streamline reporting processes and better align agency data collection activities with current federal and state practices.*

Health Care Access

Certificate of Need Program

Through the administration of the CON program for hospitals, surgical facilities and other health care facilities, OHCA ensures service accessibility for citizens while regulating duplication or excessive capacity of services. In 2005, OHCA issued 87 CON decisions, 110 CON determinations and 49 CON modifications. **Figure 1** below illustrates 2005 CONs by type.

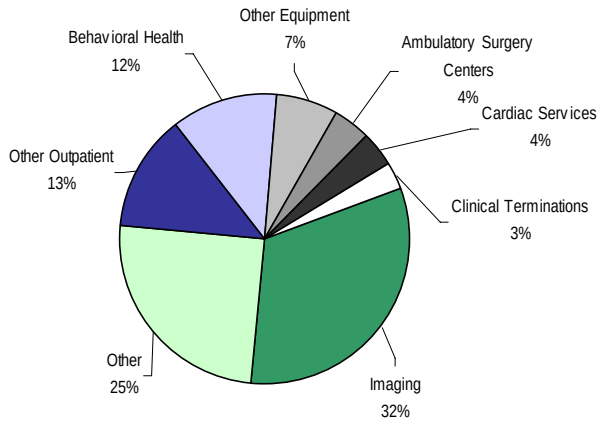
Three major trends are reflected in the types of 2005 CON applications and determinations: (1) the rate of acquisition of new and replacement equipment by hospitals and doctors' offices continues to increase; (2) hospitals and other health care providers are seeking to enhance access and quality of care available to their patients by offering new or expanded services; and (3) hospitals are undertaking major renovation projects and upgrades to physical space.

In 2005, Connecticut hospitals and physicians continued to replace and upgrade equipment to improve diagnosis and quality of care. Many of the MRI and CT scanners requested to be replaced were outdated and unable to perform necessary diagnostic procedures. Additionally, PET scanning technology was replaced by PET/CT scanning technology, thereby enhancing the diagnostic capabilities of providers.

The recent flurry of activity in the expansion of cardiac services slowed in 2005. Lawrence and Memorial Hospital was authorized to establish a primary angioplasty service without open heart surgical backup. Norwalk Hospital requested authorization to establish a full service cardiac program including angioplasty and open heart surgery, which was denied, and Stamford Hospital requested authorization to offer elective angioplasty and open heart surgery. The hospital's request was approved by an Agreed Settlement in January 2006.

In 2005, there was an expansion of ambulatory surgery centers, imaging centers and cancer centers. Hartford Hospital and Connecticut Surgical Group, P.C., d/b/a West Hartford Surgery Center, LLC, were authorized to establish and operate an ambulatory surgery center in West Hartford. Ridgefield Surgical Center, LLC, a joint venture between Danbury Health System, Inc. and area physicians, was authorized to establish and operate an ambulatory surgery center in Ridgefield, Connecticut. Danbury Health Care Affiliates, Inc. was authorized to establish and operate an outpatient imaging center in Ridgefield. Yale-New Haven Hospital was authorized to construct the North Pavilion Building and establish the Yale-New Haven Cancer Center. The Hospital of Saint Raphael was authorized to replace and upgrade radiation therapy equipment at its McGivney Cancer Center and establish a radiation therapy satellite facility in Hamden, Connecticut. These new centers will improve regional access and quality of patient care.

Figure 1: CONs by Type



During 2005 OHCA reviewed and acted on numerous CON applications for expansions and renovations to hospital physical plants. Four hospitals received authorization to expand and undertake renovations to their emergency departments and Backus Hospital, Middlesex Hospital and the Hospital of Saint Raphael were authorized to undertake major facility renovations. These renovations resulted in an increase of 99 available beds. The agency also approved, under an agreed settlement, a request to consolidate the operations of both New Britain General Hospital and Bradley Memorial Hospital under a single license. OHCA approved approximately $537 million in facility development projects, $74 million in imaging equipment and $18.5 million in surgical facilities in 2005. All 2005 CON Decisions and Determinations can be found at http://www.ct.gov/ohca.

Declaratory Ruling

In May 2005, OHCA initiated a declaratory ruling process under Docket Number 05-30498-DCR in order to determine: "*Whether the term "imaging center" as used in Conn. Gen. Stat. §19a-630 means a facility, institution, provider or persons that purchases, leases or accepts donation of any imaging, scanning or other similar equipment utilizing such technology.*" The purpose of the proceeding was to elicit information from affected parties as to the appropriate definition of the term imaging centers as used in OHCA's statutes and regulations. In a final decision issued in November 2005, OHCA concluded that the formation of the meaning of the term imaging center will not be declared through the declaratory ruling process initiated under Docket Number 05-30498-DCR due to the lack of sufficient evidence gathered by and presented to the agency as part of that declaratory ruling process.

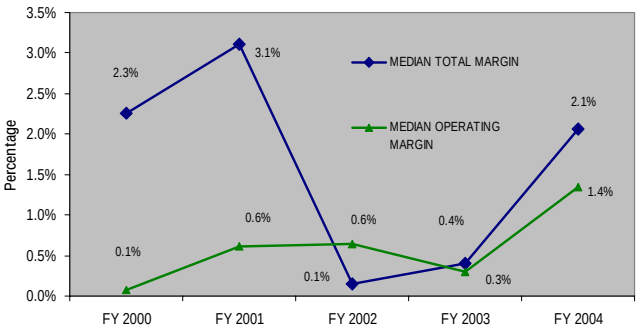
The overall financial health of Connecticut's 31 acute care hospitals improved markedly in FY 2004 . . . Twenty three hospitals reported a gain in total operating revenue, an increase from 18 in FY 2003, and twenty six hospitals reported a positive total margin, up from 19 in FY 2003.

Financial Analysis and Forecasting

Financial Status of Connecticut's Hospitals

In 2005, OHCA continued to collect and analyze historical financial results for Connecticut's hospitals and published its annual report on the financial status of the state's acute care general hospitals, as mandated by statute. The overall financial health of Connecticut's 31 acute care hospitals improved markedly in FY 2004. In FY 2004, the most recent year for which data is available, Connecticut hospitals' total gross revenue increased 15% to $12.4 billion, while hospital net revenue increased 9% to $5.7 billion. Outpatient net revenue increased by another 1% and now account for 39% of hospital revenue. Total patient days rose by 3%, and full time equivalents rose 1% during the year. Net revenue from government payers remained constant at 51% of net revenue.

Figure 2: Statewide Median Total and Operating Margins



Source: Connecticut Acute Care Hospital Audited Financial Statements

Hospitals continue to be challenged by both internal and external operating issues and face an increasingly unpredictable level of net revenues to cover rising operating expenses. The two most widely used indicators for measuring profitability are *operating margin* and *total margin*. For both measures, higher ratios imply greater profitability. Operating margin includes a surplus or loss from operating revenue only. As shown in **Figure 2**, the statewide hospital median total margin

increased from 0.4% in FY 2003 to 2.1% in FY 2004 due to increases in both gains from operations and other operating income. The statewide hospital median operating margin increased from 0.3% in FY 2003 to 1.4% in FY 2004.

Twenty three hospitals reported a gain in total operating revenue, an increase from 18 in FY 2003, and twenty six hospitals reported a positive total margin, up from 19 in FY 2003. For a second year, the statewide total margin continued to increase, helped by increases in hospital investment portfolios. Hospitals rely on the added income generated from gifts and bequests as well as the appreciation in the value of their financial assets to subsidize low gains and losses from operations and to continue to invest in new plant and equipment. OHCA has used forecasting techniques to project hospital revenue and expenses in conjunction with the CON review process to better understand and predict individual hospital performance.

Uncompensated Care

Patients at Connecticut's hospitals are treated regardless of their ability to pay, with the exception of non-emergency care such as elective or cosmetic surgery. Uncompensated care represents the level of charges for which hospitals do not receive reimbursement. There are two levels of uncompensated care: (1) free care which occurs when a hospital provides care knowing in advance it will not receive payment, and (2) bad debts, which occurs when a hospital provides care and later discovers there will be no payment. In FY 2004, Connecticut hospitals reported total uncompensated care (bad debts and free care) charges of $357 million. The actual cost to the hospital for providing this uncompensated care was $164 million. As a percentage of total hospital expenses, the uncompensated care cost to hospitals was approximately 2.9% in FY 2004.

Disproportionate Share Hospital (DSH) Program

Since the inception of the Disproportionate Share Hospital (DSH) Program in December 1991, funds have been provided to Connecticut acute care hospitals based on each hospital's uncompensated and undercompensated care as a percentage of the statewide totals. Using the financial data filed annually by hospitals, OHCA performs the calculations for the DSH program. DSH funds of $63,725,000 were distributed to hospitals in 2005.

New Hospital Financial Regulations

In September 2005 OHCA held a workshop for the state's 31 acute care hospitals to present and seek input concerning proposed new Hospital Financial Regulations that will be applied to annual filings to OHCA by the hospitals. As a result of this interactive process, the new regulations will be finalized next year and will be reviewed by the Office of the Attorney General and published in the Connecticut Law Journal.

Research and Planning

Efforts to Improve Access to Health Insurance Coverage

The Office of Health Care Access has received federal Health Resources and Services Administration (HRSA) State Planning Grant (SPG) funds annually since 2001 to examine the issue of the uninsured and to assist in planning for insurance coverage options. As part of its planning grant efforts, OHCA conducted separate household and employer telephone surveys in 2001 and 2004. These surveys provided information about the state's population, including insurance coverage status, duration of uninsurance, demographic details and availability of employer based coverage. The 2004 surveys revealed that a high percentage of uninsured people and Medicaid recipients were working and might have access to employer sponsored insurance (ESI) coverage.

In order to better quantify this population and further study barriers these workers face in obtaining employer based coverage, OHCA conducted more focused surveys of working HUSKY families, other low wage workers along with their employers in 2005. The surveys were fielded in the fall of 2005 by the University of Connecticut's Center for Survey Research and Analysis (CSRA).

Among the 17,000 eligible but not enrolled in employer-sponsored coverage, almost 13,000 cited cost as the main reason.

By specifically surveying working families and their employers, OHCA has learned more about their access to ESI as well as the issues employers face in providing health coverage. More than three quarters of the employers surveyed reported offering coverage. However, OHCA's surveys revealed that nearly one in five "working HUSKY families" are headed by someone without health insurance coverage, and almost half are headed by someone with public coverage. While an estimated 40,000 are eligible for employer-based health coverage, just over 23,000 heads of these families are currently enrolled. Among the 17,000 eligible but not enrolled in employer-sponsored coverage, almost 13,000 cited costs as the main reason. For example, a family of three earning between 100 percent and 150 percent of the Federal Poverty Level (FPL) ($16,000 to $24,000) would need to spend between 12 and 17 percent of its annual total income to pay its portion of the least expensive family coverage offered by HUSKY employers (employee's annual family premium $2,760).

The HRSA State planning grant program has been an important resource to states looking to develop strategies to improve access to insurance coverage. Grantees receive funding to collect new data and study health insurance trends in order to develop coverage options for the uninsured. OHCA will be conducting new statewide household and employer surveys in the Spring of 2006 utilizing grant funds.

Preventable Hospitalizations Study

Preventable hospitalizations are defined as instances of inpatient hospital care for ambulatory care sensitive conditions (ACSCs) that are considered "preventable" because timely and effective primary care and medical management have been clinically demonstrated to reduce the need for hospitalization. In 2005, OHCA undertook a study of preventable hospitalizations utilizing a national standard developed by the Agency for Healthcare Research and Quality (AHRQ) clinical experts under the auspices of the U.S. Department of Health and Human Services. The standard, AHRQ's Prevention Quality Indicators (PQIs), are a set of measures that can be used with hospital discharge data to identify hospital admissions that are potentially avoidable through effective treatment in the community-based primary care system. The 16 ACSC conditions OHCA studied included pneumonia, congestive heart failure, adult and pediatric asthma, chronic obstructive pulmonary disease, diabetes-related conditions and low birth weight babies.

According to OHCA's study, there were over 50,000 hospitalizations of Connecticut state residents in 2004 that may have been prevented, with associated charges of almost $900 million. Preventable hospitalization volume may identify the possibility of gaps in the primary care health system, disease management (both by provider and patient) and access to health services that lead to increased disease severity and ultimately, hospitalization.

Connecticut compared favorably with national preventable hospitalization rates, with a lower prevalence for 15 of the 16 conditions studied. The exception was the state's incidence of low birth rate babies, with Connecticut's rate slightly above the U.S rate (6.8 versus 6.0 per 100 births). While Connecticut fared better than the nation, OHCA's study identified certain age, race and geographic disparities within the state. Addressing these disparities and the cost of preventable hospitalizations are challenges faced by local and state authorities as well as providers.

The preventable hospitalization study can be used as a screening tool identifying unmet health care needs and possible gaps in the health care system, not just in the state as a whole, but in the local communities. In response to OHCA's study, numerous local health care providers and health authorities have requested ACSC information for their communities. Hospitals, community health centers, local departments of public health have requested and received community specific information. They are using this information to design community outreach services, particularly those for the care and management of chronic illnesses such as diabetes and asthma.

Local providers are also incorporating data from the study into grant applications for such projects as disease management programs, chronic illness awareness education targeting both the general public and physicians, and increased specialist care at community health centers. OHCA has provided insurance carriers with additional preventable hospitalization information they required to analyze the effectiveness of disease management programs as cost containment strategies.

Evaluation of Pediatric Psychiatric Beds

Section 91 of Public Act 05-280 "An Act concerning the expenditures of the Department of Social Services" required the Commissioner of the OHCA to establish a committee to examine whether the licensed hospital psychiatric inpatient bed capacity for children in the state is sufficient and what steps, if any, are necessary to expand such capacity. The committee consisted of the Commissioner of the Department of Social Services and the Commissioner of the Department of Children and Families or their designees; the state Child Advocate or designee; representatives of private children's hospitals; and mental health advocacy groups for children. The Office of Health Care Access reported the findings and recommendations of the Committee to the General Assembly in January 2006.

Graduate Medical Education

OHCA continued, per statutory mandate, to report on Graduate Medical Education (GME) in Connecticut. Seventeen of the state's teaching hospitals received approximately $194.9 million in graduate medical education funding from Medicare and Medicaid in 2003 (the most recent year for which complete data were available), an overall decrease of with Medicare direct and indirect GME payments totaling $49.9 and $137.5 million, respectively.

Inpatient Hospital Discharge Abstract and Billing regulations

In 2005, OHCA drafted revised Inpatient Hospital Discharge Abstract and Billing Regulations. The revised regulations are intended to better track the delivery of and access to inpatient acute care health services in Connecticut; enhance clarity, quality and utility of the information collected; update procedures for disseminating electronic health care data while ensuring patient confidentiality in compliance with state, local and federal privacy standards; make non-confidential health care data more accessible to the industry and the public; and ensure that health care data collected is consistent with and comparable to other states' data. OHCA will seek industry input on the proposed regulations before finalizing and submitting for review by the Office of the Attorney General and subsequently, the Regulations Review Committee of the General Assembly.

Emergency Department Work Group

Emergency department (ED) care is a critical component of Connecticut's health care delivery system, providing care for seriously ill and injured patients and serving as the safety net for many who may not have access to other available resources. The state's EDs face a variety of challenges in providing care. Systemic issues such as staffing, bed availability and patient flow, as well as a myriad of external factors, can influence the effectiveness of the state's EDs. To better understand Connecticut's ED utilization and access issues, OHCA convened an ED Work Group in 2005. As part of its activities, the work group provided recommendations for addressing bed, staffing, wait time, transportation and internal process systems issues.

Legislative Update

To alleviate concerns regarding parity and quality of imaging equipment, the 2005 Office of Health Care Access legislative session was highlighted by the passage of Public Act 05-93, "An Act Concerning the Capital Expenditure Threshold for the Regulation of Equipment Acquisitions." This public act requires CON approval, regardless of cost, for anyone acquiring, purchasing or accepting donation of a CT scanner, PET scanner, PET/CT scanner, MRI, cineangiography equipment, a linear accelerator or other similar equipment utilizing new technology that is being introduced to the state. Prior to this new law, a $400,000 or more purchase, acquisition or accepted donation of imaging and scanning equipment triggered the CON review. In some cases this law may have provided an incentive to purchase, acquire or accept donation of equipment of lesser quality in order to avoid regulatory oversight. The Office of Health Care Access believes this law will provide the citizens of Connecticut with a higher quality of imaging and scanning services.

2005 OHCA Publications

Each year, the Office of Health Care Access publishes a variety of reports about health care in Connecticut. These reports provide policy makers, providers, payers and members of the general public with objective, accurate and timely health care information. Below is a list of all 2005 publications. Copies of all reports are available on the agency's website at http://www.ct.gov/ohca.

SNAPSHOT: Connecticut's Health Insurance Coverage- 2004 Household Survey (January 2005)

OHCA Annual Report on the Financial Status of Connecticut's Acute Care Hospitals (2003 data, published 2005) (February 2005)

Graduate Medical Education in Connecticut (FY 03 data, published 2005) (March 2005)

Why Premium Assistance Strategies Can Succeed in Connecticut (March 2005)

DATABOOK: Preventable Hospitalizations in Connecticut: Assessing Access to Community Health Services (September 2005)

Connecticut Acute Care Hospital Fiscal Year 2004 Statewide Financial Analysis (October 2005)

Eroding Private Sector Employer Sponsored Health Insurance and Rising Costs: 2003 Medical Expenditure Panel Survey (MEPS) Results (November 2005)

Report of the Committee to Examine Hospital Inpatient Behavioral Health Bed Capacity for Children (published January 2006)

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